PATIENT INFORMATION **PRIVATE/ SECONDARY** **DATE:**_____

(Please Print, Black Ink Only)

Patient Name:_____ Home Phone: _____

Address:_____ Cell/Pager#:_____

City & State: _____ Zip:_____ e-mail: _____

Date of Birth: _____ Marital Status: S M D W Sex: M F Soc. Sec#: _____

Responsible Party:_____ **Relationship to patient**:_____

Employer: _____ Bus. Phone: _____

Address: _____ City & State: _____Zip: _____

Occupation: _____

Emergency Contact:_____**Telephone**:_____

Physician's Name: _____UPIN#: _____ NPI #: _____

Address: _____City & State: _____Zip: _____

Telephone: _____ Fax: _____

Dx:_____ Surgery? Yes/No Date of Sx: _____

Primary Ins.: _____Telephone: _____

Address: _____City & State: _____Zip: _____

Insured's Name: _____

ID# / SS: _____ **Group**/Policy#:_____

Deductible $_____ Met? Yes / No – How much has been met? $ _____ P.T. Paid at _____%

Co-Pay per visit $_____ Policy Limits (#Visits/Max $ Per day/Exclusions) _____

Out of Pocket Max $_____ Met? Y/N – How much has been met? $ _____ _____

Effec. Date: _____ On Account to keep up with co-insurance balance $_____

Requires Pre-Auth? YES / NO Is CPRx a contract provider? YES / NO Benefits given by: _____

Auth #: _____

Secondary Ins.: _____Telephone: _____

Address: _____City: _____ Zip: _____

Insured's Name: _____

ID# / SS: _____**Group**/Policy#: _____

Deductible $_____Met? Yes / No - How much has been met? $_____ P.T. Paid at_____%

Co-Pay per visit $_____ Policy Limits (#Visits/ Max $ Per Day/ Exclusions) _____

Out of Pocket Max $_____ Met? Y/N – How much has been met? $ _____ _____

Effec. Date: _____ On Account to keep up with co-insurance balance $_____

Requires Pre-Auth? Yes/No Is CPRx a contract provider? YES / NO Benefits given By: _____

Auth #: _____

Who referred patient / How did patient hear of our facility? _____

Therapist #_____ Appt. Date & Time: _____ Revised Dec 2007

Patient's Signature _____ CPRx Officer Signature _____

☐ Ins Coverage Info ☐ Billing Face Sheet ☐ Staffing Sheet ☐ Stamp Charts ☐ Doc's List